Prenatal Care

A Group Psychotherapeutic Approach

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• **It has been well established that "normal" pregnancy gives rise to much anxiety whose source is variable. When not adequately dealt with, the anxiety may masquerade in the guise of physical symptoms such as fatigue, dizziness, nausea and vomiting, or, more often, as disquieting emotional counterparts, like irritability and depression.**

A study was undertaken in the outpatient obstetrical department at U.C.L.A. utilizing a group psychotherapeutic approach. The results helped the patients and offered training to staff in dealing with emotional problems of pregnancy. Patients were seen in groups of seven, twice a month for one-hour sessions. Participating in each group were an obstetrical resident, a psychiatric resident and a nurse. The subject material was not selected beforehand. Groups were similar in that the expected time of delivery of the patients was approximately the same. Results of the study suggested that the much needed emotional support may be supplied in this way with little to no additional time expenditure on the part of the physician or nurse.

IN THE FIELD of obstetrics, much has been written regarding the emotional requirements of the prenatal patient,[1,2,12,18-22] and varying attempts at teaching psychiatric skills to the resident are being made.[10] Ideal prenatal care should have as its goals not only the continuing reduction of morbidity and mortality, but the emotoional well-being of the patient and her family as well. Programs have variably stressed education, relaxation and exercise,[8,24] and have utilized physical therapists and lay educators in order to free the obstetrician-nurse team to deal more effectively with the reduction of morbidity. It is difficult to criticize the value and merits of the individual programs. Certainly all are good in the sense that they attempt to answer a need. Whether the relegation of authority away from the physician is a good thing has been questioned.[13,17]

Although the present-day medical curriculum emphasizes the need for recognition and treatment of psychosomatic aspects of disease, too often in pursuit of specialty training programs, the resident physician finds little time available to deal effectively with even the most superficial anxieties that trouble his patients. Usually these anxieties are countered by authoritative reassurances and generally harmless drugs, which fortunately in the majority of instances offer sufficient temporary relief. This way of dealing with such problems may stem from a tacit "understanding" between physician and patient. The patient disguises emotional problems in a garb of physical complaints, and the resident physician, even though aware of the emotional origin of the problems, willingly treats them as physical. If the "palliative tablet" does not help or the emotional problems are more severe, psychiatric referral is always at hand. This practice avoids the strain of closer personal involvement with patients and helps perpetuate the dichotomy already existing between the treatment of physical and emotional disease.

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The authors pondered whether many of the programs might not be allaying anxiety indirectly rather than getting down to the primary sources, and, further, whether the obstetrician could not deal with these more directly and thus more effectively. Could it be done without further encroaching upon the time of the busy resident who was desirous of offering his patient more than routine care?

For answers, using group psychotherapeutic techniques, we attempted to utilize the well established principles of prenatal care and at the same time more directly meet the emotional needs of the patient. Group therapy has been shown to be an effective method of treating anxiety associated with a variety of illnesses, both psychic and somatic.[6,9,23,30] Its use in obstetrics, in a formal sense, is rare, and its use with a psychiatrically "normal" pregnant population has been reported only twice to our knowledge.[7,16] Although group processes are an integral part of many prenatal programs, they generally are used in an indirect fashion. It is quite common, however, to find groups of women sharing their experiences about pregnancy.[12,18]

Our study was based on the following considerations: (1) All "normal" pregnant women have substantial amounts of anxiety which ultimately affect the course of the antenatal period both physically and emotionally, their labor and delivery and their subsequent relationship to the newborn and to their family. (2) Many sources of the anxiety can be readily discovered and understood, and the anxiety diminished by utilizing group therapeutic techniques. (3) Such a program is practical for teaching residents, students and nurses how to deal with the emotional problems of pregnant women. (4) The program is not neglectful of the many physical problems that may arise in the course of pregnancy and it requires no extra expenditure of time by the physician.

METHOD

This pilot study was undertaken in the out-patient clinic of the Department of Obstetrics and Gynecology of the U.C.L.A. School of Medicine. Twenty-one experimental subjects and 48 controls were included, unselected except for the following criteria: (1) No overt psychiatric disorder was present; (2) the subjects had reasonable facility with and comprehension of the English language; and (3) they were willing to participate.

The subjects were divided into three groups of seven on the basis of similarity of trimester. At their first visit to the clinic a history was taken and a physical examination carried out by a medical student and an attending obsetrician. Then the patients were given appointments to the first group meeting. Routine laboratory work, immunizations, and Mantoux testing were done at this time. One-hour meetings were held twice a month in a conference room equipped with a one-way mirror and microphones for purposes of recording the discussion. Before each meeting, urinalysis was carried out and weight and blood pressure were recorded by nurses.

At the first meeting the patients were informed that they had been arbitrarily assigned to us for their prenatal care and that we chose to meet in a group setting in order to discuss together problems common to pregnancy. We did not identify our groups as experimental. In order to lessen differences between persons in the experimental group and the controls, we encouraged participation in our regular evening educational lecture-film series which were available to all our obstetrical patients. Referrals to neighboring Y.W.C.A. courses were given to those expressing interest in natural childbirth training; participation in those courses was neither encouraged nor discouraged. Individual appointments with the obstetrical resident were made at approximately 24 weeks and again at 37 weeks. These were held in the regular obstetrical clinic examining rooms and the usual prenatal examinations were performed.

TABLE 1.—*Total Hours Spent by Physician and by Patient in Group Program as Compared with the Usual Clinic Program.*

Month of Pregnancy	Usual Program		Group Program	
	No. of Visits	Time in Minutes	No. of Visits	Time in Minutes
3rd; first visit	1	60	1	60
4th	1	10	2	120
5th	1	10	2	120
6th	1	10	*2	120
7th	2	20	2	120
8th	2	20	2	120
9th	4	40	*2	120
Total visits and hours	12	2 hr. 50 min.	13	13 hr.
Resident physician Total hours		19 hr. 50 min.		15 hr. 20 min.

*10 minute visit with physician.

Each of the bimonthly group sessions was attended by an obstetrical resident, a psychiatric resident and two nursing instructors. When guests were present in the adjoining observation room their presence was discussed and permission was obtained for the use of the microphones. Topics were spontaneously introduced from the group. The participants were encouraged to answer the questions of others in the group except when an authoritative reply was expressly asked of the physician. Occasionally, on the initiative of the resident or patient, other individual appointments were arranged as indicated. There was no evidence that this occurred any more frequently than it did with the control group. Although the physician-patient relationship was more intimate and intense, it did not result in appreciably greater demands on his time than were made in the routine clinic program.

Table 1 shows a comparison of actual hours spent by physician and patient in the group program and in the usual clinic program.

TESTS AND RESULTS

Psychological testing was done (1) to describe the patient groups, (2) to record their attitudes toward pregnancy,* and (3) to evaluate changes in morale and in attitudes as a part of pregnancy and as a result of the group sessions.

Fifty-one subjects completed the Shipley Institute of Living Scale, the scores of which were converted to estimated scores on the Wechsler Adult Intelligence Scale.[29] The average estimated Wechsler intelligence quotient was 109, somewhat above the adult population average. There were only small, nonsignificant differences between the experimental

*References 18, 22, 25-28, 35, 36.

and the control groups and between the primiparous and multiparous patients.

Forty-two patients completed the Minnesota Multiphasic Personality Inventory (MMPI) early in their clinic contacts.[15] On the eight major psychopathology scales, the group averages were approximately one-half to one standard deviation in the pathological direction from the adult normal average.[34] An overall 45 per cent had one or more scores in the pathological range, as contrasted with from 15 per cent to 20 per cent pathological profiles among unselected, non-psychiatric adults. About one-third of the patients showed mild to moderate sociopathic trends, suggesting traits of nonconformity, rebellion and lack of self-restraint or inhibition. (Perhaps inhibited and particularly modest women avoid such a teaching clinic.) A smaller subgroup had profiles indicating mild depressions, and the other profiles were of varied types. There was a slight but significant tendency for the multiparous patients to have more pathological profiles, although this was not concentrated in any area of psychopathology. Postnatal testing was not sufficiently complete to show clear trends.

An inventory of 104 True-False items pertaining to pregnancy, childbirth and related attitudes was developed. Sixty-seven women completed this form at or shortly after their first clinic contact, including both treatment group patients and controls.

Several of the items reflected a very positive interest in discussing personal problems with their physician. Ninety-five per cent responded "True" to the statement, "Talking about my worries and fears makes me feel much better." Eighty-seven per cent felt their physician was interested in them as a person, and only 9 per cent were afraid that the physician would think less of them if they talked about their fears. Sixty-three per cent explicitly agreed, "I would feel comfortable telling my doctor my personal problems."

Among these women 56 per cent reported they would like to go through "natural childbirth" and 71 per cent wanted to be awake when their baby was born. Sixty-three per cent felt a husband should stay with his wife throughout labor, and to the item, "I think that if both husband and wife wish it, the husband should be allowed to watch the delivery," 89 per cent answered "True."

In comparing the answers of the primiparous patients with those of the multiparous, more of the latter were unhappy about being pregnant. This was reflected in the attitude on such items as: "Most women are happy to be pregnant"; "Early in the pregnancy, losing the baby would have been OK in some ways"; "I wish my husband knew what it was like to be pregnant."

To further analyze these items, nine of the obstetricians were asked to answer the 104 items "as you would expect an average pregnant woman to answer them." Four of these men were members of the staff and five were residents. They were consistently in error on only 20 per cent of the items—a high accuracy compared to many response prediction studies. Their errors were very largely among items reporting fears, inhibitions and frustrations, where they expected the negative feelings to be consistently expressed, but they were not. These included such feelings as fear of childbirth, of losing the baby or that the baby would be abnormal, resentments of the husband, and fear of losing one's figure. It is an open question whether the women were covering over these feelings or actually were not distressed by them as consistently and as intensely as expected.[5,12,18]

Where a majority of the staff predicted one answer (True or False) and the residents predicted the opposite, the staff was right 31 times of 34. This would directly suggest that one increasingly learns these patient attitudes with continuing experience. The point offered here is that group sessions such as were held in this project offer an ideal situation to learn and understand these patient attitudes.

COMMENT

In evaluating the results of our experience we felt that the experimental sample was too small to offer a sound basis for broad generalization. Nevertheless, a number of our subjective impressions seem to deserve mention.

The concept of the "ideal pregnant woman," as proffered by theoretically oriented investigators, implies that significant anxieties in pregnancy are pathological.[4,12] Our experience, corroborating the writings of others,* suggests that "normal" pregnant women have many anxieties; the extent and universality of anxieties are greater than we had expected.

Multigravid patients, in contrast to prevailing opinion, are equally in need of emotional support during pregnancy, for often the experiences of previous pregnancy seem to enhance rather than diminish anxiety.

The work of Bibring suggests that much of the florid psychopathologic manifestations of parturients is limited to the pregnant state. This might be made analogous to other stressful periods in the emotional growth of the individual (adolescence, menopause). One might argue that this emotional stress is usually handled by the natural "healing processes" inherent in the individual, and that there is no need for assisting these processes with psychotherapy, since the effort might aggravate emo-

*References 5, 8, 18, 20, 24.

tional conflicts which might better be left undisturbed. It was not our impression that the group method aggravated psychopathologic states; rather, it clearly seemed to relieve the existing anxiety. An interesting but technically difficult study to undertake would be one wherein psychological examinations could be performed on a series of pregravid patients who would then serve as their own controls during a subsequent pregnancy. This might lead to the documentation of patterns of profile shift in reaction to pregnancy, about which the authors could only speculate at this time.

Fear of pain, mutilation and possible death, loss of self control, changes in body image and bodily sensations, the possibility of a defective child and relationships with physicians, nurses and hospitals were major sources of anxiety expressed in the group sessions. Preexisting conflicts with parents, husbands and other authority figures frequently appeared to be exacerbated by the demands of pregnancy. Other sources of anxiety, rarely discussed, concerned sexual relationships, contraception, guilt and resentments toward medical personnel.

The manifestations of anxiety were predominantly depression[32] and somatic complaints. These symptoms appeared coincidentally with periods of emotional stress and seemed to remit coincidentally with the resolution of emotional conflicts.

We began the meetings with set agenda and various other formal approaches which we soon recognized as manifestations of our own anxiety. With additional experience and an awareness of the gradual formation of a group identity, we were able to permit the patients to discuss topics of greatest importance *to them*. Our subsequent activity was only to stimulate the discussion and to moderate it as necessary. The patients too, at first, were anxious about the meetings. The majority, however, soon became comfortable, enthusiastic and cooperative. In some, significant changes in attitudes were apparent, with considerable reduction of preexistent fears, a mature acceptance of responsibility of motherhood and a realistic awareness of psychic causation of various somatic symptoms. A few patients remained uneasy and unenthusiastic throughout the period of prenatal care. These women seemed to be those who were either inherently suspicious and defensive or who had developed a life-pattern of dealing with emotional stresses by somatization. To these women our attitude that emotional stresses could be pertinent to their physical wellbeing was antithetical. It appeared nevertheless that they experienced some diminution of their anxieties as pregnancy progressed, and they certainly stimulated the groups to lively controversy over the issues that were stressful to them.

Discussion with the participating nurses after the group sessions revealed the presence of a strong rapport between patients and nurses that differed somewhat from the relationship of the patients to the physicians.[33] This observation is, of course, not unique to this experimental situation and is probably related to both the difference in sex and the different roles the patient assigns to those who undertake her care. An awareness of this rapport and its source suggested that we utilize the nurses in an active therapeutic role within the group structure. Their presence subsequently served as an additional source of information and they provided critical observations to evaluate the group processes. The experience afforded the nurses a greater amount of intellectual stimulation than that ordinarily present in routine clinic care and tapped an otherwise dormant source of therapy.

As a training device we feel such a program offers many advantages not present in more didactic settings for the teaching of psychiatric skills. It entails no further time expenditure on the part of an already busy obstetrical resident. It enhances the working rapport of the participating disciplines and the primary emphasis upon patient care. Of additional benefit to the psychiatric resident is the opportunity to deal with "normal" subjects and to practice preventive psychiatry. The obstetrical resident under guidance gradually loses his sense of discomfort, usually present in his dealing with psychosomatic disease, and can begin to handle such problems with greater skill and understanding through repeated exposure. We believe that either resident, alone, could conduct the meeting as a result of the experience gained, and that an obstetrician with psychiatric orientation would feel quite comfortable in the group atmosphere.

The expedient alleviation of emotional problems through group psychotherapy is well known in fields of medicine other than obstetrics.[6,14,23,30] Its efficiency in helping small groups of patients with common problems has been demonstrated in psychiatric disorders and psychosomatic conditions. From the limited experience herein described, utilizing it in a prenatal program seems to us quite promising.

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